| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
| *Company Tracking Number:* | *AR RA 5/09* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

## Filing at a Glance

Company: American Community Mutual Insurance Company

| | | |
|---|---|---|
| Product Name: Re-Write Application | SERFF Tr Num: AMCM-126125890 | State: ArkansasLH |
| TOI: H16I Individual Health - Major Medical | SERFF Status: Closed | State Tr Num: 42238 |
| Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) | Co Tr Num: AR RA 5/09 | State Status: Approved-Closed |
| Filing Type: Form | Co Status: | Reviewer(s): Rosalind Minor |
| | Author: Michele Sapikowski | Disposition Date: 05/01/2009 |
| | Date Submitted: 04/28/2009 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: | Status of Filing in Domicile: |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: Exempt from filing in the state of Michigan |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Group Market Size: |
| Overall Rate Impact: | Group Market Type: |
| Filing Status Changed: 05/01/2009 | Explanation for Other Group Market Type: |
| | State Status Changed: 05/01/2009 |
| Deemer Date: | Corresponding Filing Tracking Number: |

Filing Description:

Enclosed for review and approval is form AR RA 5/09, Arkansas Re-Write of Existing American Community Individual Health Insurance. This application will be used in the individual market by people currently insured by us who are seeking to apply for a different product with us. This is a new form and does not replace any forms currently in use in your state.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
| *Company Tracking Number:* | *AR RA 5/09* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

Any bracketed material represents variable information. No such items will be contradictory to any applicable state or federal law. This form is exempt from filing in our domiciliary state of Michigan.

## Company and Contact

**Filing Contact Information**

Patricia Robbins, Sr. Compliance Specialist
39201 Seven Mile Road
Livonia, MI 48152

probbins@american-community.com
(734) 591-4708 [Phone]
(734) 591-4628[FAX]

**Filing Company Information**

American Community Mutual Insurance Company
39201 Seven Mile Road
Livonia, MI  48152
(800) 991-2642 ext. [Phone]

CoCode: 60305
Group Code:
Group Name:
FEIN Number: 38-1290976
---

State of Domicile: Michigan
Company Type:
State ID Number:

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $20.00 |
| Retaliatory? | No |
| Fee Explanation: | 1 application = $20.00 |

ACMIC use only: acct# 6200030

Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| American Community Mutual Insurance | $20.00 | 04/28/2009 | 27479693 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
| *Company Tracking Number:* | *AR RA 5/09* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

## Company

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
| *Company Tracking Number:* | *AR RA 5/09* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 05/01/2009 | 05/01/2009 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
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| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

# Disposition

Disposition Date: 05/01/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
| *Company Tracking Number:* | *AR RA 5/09* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | Yes |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Form** | Re-Write Application of Existing American Community Individual Health Insurance | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
| *Filing Company:* | *American Community Mutual Insurance Company* | *State Tracking Number:* | *42238* |
| *Company Tracking Number:* | *AR RA 5/09* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.005A Individual - Preferred Provider (PPO)* |
| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

# Form Schedule

**Lead Form Number:** AR RA 5/09

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed | AR RA 5/09 | Application/ Enrollment Form | Re-Write Application of Existing American Community Individual Health Insurance | Initial | | 40 | AR RA 5-09.pdf |

# Arkansas
# Re-write of Existing American Community Individual Health Insurance

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000 (734) 591-4628 Fax
www.american-community.com

## PART I

**INSTRUCTIONS FOR KEY APPLICANT** This application is to be used for rewriting your in force American Community Mutual Insurance Company (herein referred to as "American Community" or "AC") Individual Health Policy to a new plan of insurance, including plan changes and increasing benefits. This application cannot be used to add a dependent who is not covered by the current policy.

Thank you for applying to American Community. Your health insurance is important protection and the application process is a crucial part of securing coverage for you and your family. Please take the time to carefully complete this application; your answers will become part of the underwriting process and the insurance contract. When completing the application, please follow these procedures:

1. The Application is to be completed by the Key Applicant (Proposed Insured). Children only policies require the parent or guardian who has custody and care of the children to complete and sign the application.
2. Questions apply to each person applying for coverage (all applicants). Provide updated information regarding existing conditions since approval of existing policy as well as new conditions and changes in health status. **American Community will not routinely request medical records during the underwriting process.**
3. Please print in black or blue ink only. Signatures are to be written and must be legible (dependents age 18 and over must also sign the application).
4. Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined-out answer. Applicant must then initial and date the correction.
5. Errors in signature(s) and/or date/time cannot be corrected. A new application is required.
6. Applications should be completed and mailed as soon as possible so they are received by American Community within 30 days of the application date.
7. **Do not cancel your existing American Community insurance coverage** until your new American Community policy has been issued and the policy has been delivered and fully accepted by you. Premiums for the new policy are not required until the new application has been approved by our Underwriting Department and accepted on delivery by the Key Applicant.
8. Your new insurance at American Community will be in force when all of the following events take place:
   a. The application has been approved for policy issue by American Community's Underwriting Department.
   b. Any amendments/exclusion riders to the policy have been signed by the Applicant and received at our Home Office.
9. The effective date of coverage will be the paid-to date of the in force policy.
10. **If Applicant is changing from an American Community Group plan, please use the regular HA-1 Health Application.**
11. If you need to change the address we have on file or if you wish to change the method by which you are currently paying your premium, you need to contact Customer Service at (800) 991- 2642.

# Arkansas
# Application for Individual Health Insurance Policies-Rewrite

Please complete application in blue or black ink.

Agent #: ___ ___ ___ ___ ___

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000 (734) 591-4628 Fax
www.american-community.com

Thank you for rewriting with American Community. Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

## PART II

### A. TYPE OF APPLICATION

☐ Rewrite of existing policy with AC. Current Policy # _____

### B. PERSONS APPLYING FOR INSURANCE

**1. List all Family Members applying for insurance.** Children must be at least 15 days old and under 22 years old. Include maiden names of females in parentheses. To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school.

☐ Check here if there are more than 3 dependent children. Attach a separate page listing the additional children.

| Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.) | Relationship to Applicant | Sex M/F | Date of Birth | Height FT. IN. | Weight LBS. | Social Security Number | ✓ if FT Student |
|---|---|---|---|---|---|---|---|
| | Key Applicant | | | | | | |
| | Spouse | | | | | | |
| | Child | | | | | | |
| | Child | | | | | | |
| | Child | | | | | | |

**2.** If any proposed applicant does not live at the above address, please explain: _____

_____

**3. Contact Numbers**

| |
|---|
| Daytime Ph. # |
| Evening Ph. # |
| Spouse's Ph. # |
| E-mail Address |

**4. Occupation(s)** If self-employed, please identify or describe your occupation.

| |
|---|
| Key Applicant Occupation: |
| Spouse Occupation: |

**You may be contacted for a telephone interview.**

Please indicate the best time (between 8:00 a.m. and 5:00 p.m. Eastern Standard Time) for an interview: _____

### C. BENEFITS REQUESTED

**Please complete, sign and attach the Arkansas Product Selection Form identifying the Health Plan selected.**

### D. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)

**Please answer all questions.** **Yes** **No**

**1.** Are you, your spouse, significant other, or any dependent or adopted child now pregnant (whether or not this person is applying for coverage) or is there an adoption pending?
**If yes, Do Not Submit Application.** ☐ ☐

**2.** Has any applicant's driver's license been suspended or revoked since approval of the policy to be replaced?
If yes, please provide their name and driver's license number. ☐ ☐

Name: _____ Driver's license number: _____
If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Addendum.

**Has anyone applying for coverage (Document details of any "Yes" answers on page 3):**

**Yes** **No**

**3.** Had a change in health status since approval of the policy to be replaced? ☐ ☐

**4.** Been diagnosed or treated for any medical symptom or condition since approval of the policy to be replaced? ☐ ☐

**5.** Had any diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed? ☐ ☐

**6.** Had any symptoms or conditions for which a prudent person would seek medical advice or treatment? ☐ ☐

**7.** Taken, or currently take, any medication? ☐ ☐

**Note:** Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.

If any questions or conditions in section D are checked "Yes", please explain below (use additional paper, if necessary).
Please indicate all details of the symptoms, injury, ailment or condition. Include items such as specific location of condition, diagnosis, type of treatment, testing, and/or hospitalization.

| Question Number | Patient/Applicant | Condition, Injury, Symptom, or Diagnosis | | | Was recovery complete? | Treatment or advice given, surgery performed, diagnostic test results and medications prescribed | Name, address and phone number of doctors and hospitals |
|---|---|---|---|---|---|---|---|
| | | Condition | Date began | Date last treated | | | |
| | | | | | | | |
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**Additional Information:**

## E. CONSENT, TERMS AND CONDITIONS

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
4. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
5. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
6. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
7. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent. I know that I have the right to revoke this consent by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
8. I am signing this application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my or my dependent's health or any of the answers or statements change prior to the underwriting decision date, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my or my dependent's coverage under the policy.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.
10. I understand that this application is void if not approved within 90 days after the date the application was signed.
11. I acknowledge receipt of the Outline of Coverage for the health insurance plan selected on the Product Selection Form attached to this application.
12. I understand that the existence of other insurance may reduce the benefits under this plan.

**Signature of Key Applicant** (or if minor Child, Parent or Guardian)**: X**_____ **Date:**_____

**Signature of Spouse: X**_____ **Date:** _____

**Signature of Dependent (age 18 or over): X** _____ **Date:** _____

**WARNING**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Do not cancel your current American Community health insurance coverage until you receive an approval letter and a new insurance policy from American Community. You will be notified of the effective date of your policy.**

### PROXY

The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.

**X** _____ _____

**Signature** Date

AGENT INFORMATION: Name: _____ Number: _____

Phone # _____ Fax # _____ **Signature: X** _____

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
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| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AMCM-126125890* | *State:* | *Arkansas* |
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| *Product Name:* | *Re-Write Application* | | |
| *Project Name/Number:* | */* | | |

# Supporting Document Schedules

**Satisfied -Name:** Flesch Certification
**Review Status:** Approved-Closed 05/01/2009
**Comments:**
**Attachment:**
AR RA 5-09 - Readability.pdf

**Bypassed -Name:** Application
**Review Status:** Approved-Closed 05/01/2009
**Bypass Reason:** N/A
**Comments:**

**Bypassed -Name:** Health - Actuarial Justification
**Review Status:** Approved-Closed 05/01/2009
**Bypass Reason:** N/A
**Comments:**

**Bypassed -Name:** Outline of Coverage
**Review Status:** Approved-Closed 05/01/2009
**Bypass Reason:** N/A
**Comments:**

**AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY**
**39201 Seven Mile Road, Livonia, Michigan 48152**
**734-591-9000 • FAX 734-591-4628**
**NAIC Company #60305 • NAIC Group #166**

## READABILITY CERTIFICATION

TO: THE ARKANSAS DEPARTMENT OF INSURANCE

DATE: April 23, 2009

| Form Number | Description |
|---|---|
| AR RA 5/09 | Arkansas Re-Write of Existing American Community Individual Health Insurance |

I certify that the above form meets or exceeds a score of forty (40) on the Flesch Readability Test.

Francis P. Dempsey

Digitally signed by Francis P. Dempsey
DN: cn=Francis P. Dempsey, o=American Community Mutual Insurance Company, ou=Senior Vice-President & General Counsel, email=fdempsey@american-community.com, c=US
Date: 2009.04.23 10:16:45 -04'00'

Francis P. Dempsey, Senior Vice President
General Counsel & Corporate Secretary

April 23, 2009
DATE